# Getting to Quality Goals that Matter: Part 2

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*California Dementia Quality Healthcare Summit: Putting Tools and Resources into Practice*

May 3, 2018

# Disclaimer

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This presentation is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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No financial conflicts to disclose

# Size and Scope of CMS Responsibilities

- CMS is the largest purchaser of health care in the world.
- Combined, Medicare and Medicaid pay approximately one-third of national health expenditures (approx $800B)
- CMS covers 100 million people through Medicare, Medicaid, the Children's Health Insurance Program; or roughly 1 in every 3 Americans.
- The Medicare program alone pays out over $1.5 billion in benefit payments per day.
- Through various contractors, CMS processes over 1.2 billion fee-for-service claims and answers about 75 million inquiries annually.

# Delivery System Reform will result in better health outcomes for older adults


**Public and Private sectors**

## Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

## Systems and Policies

- Fee-For-Service Payment Systems

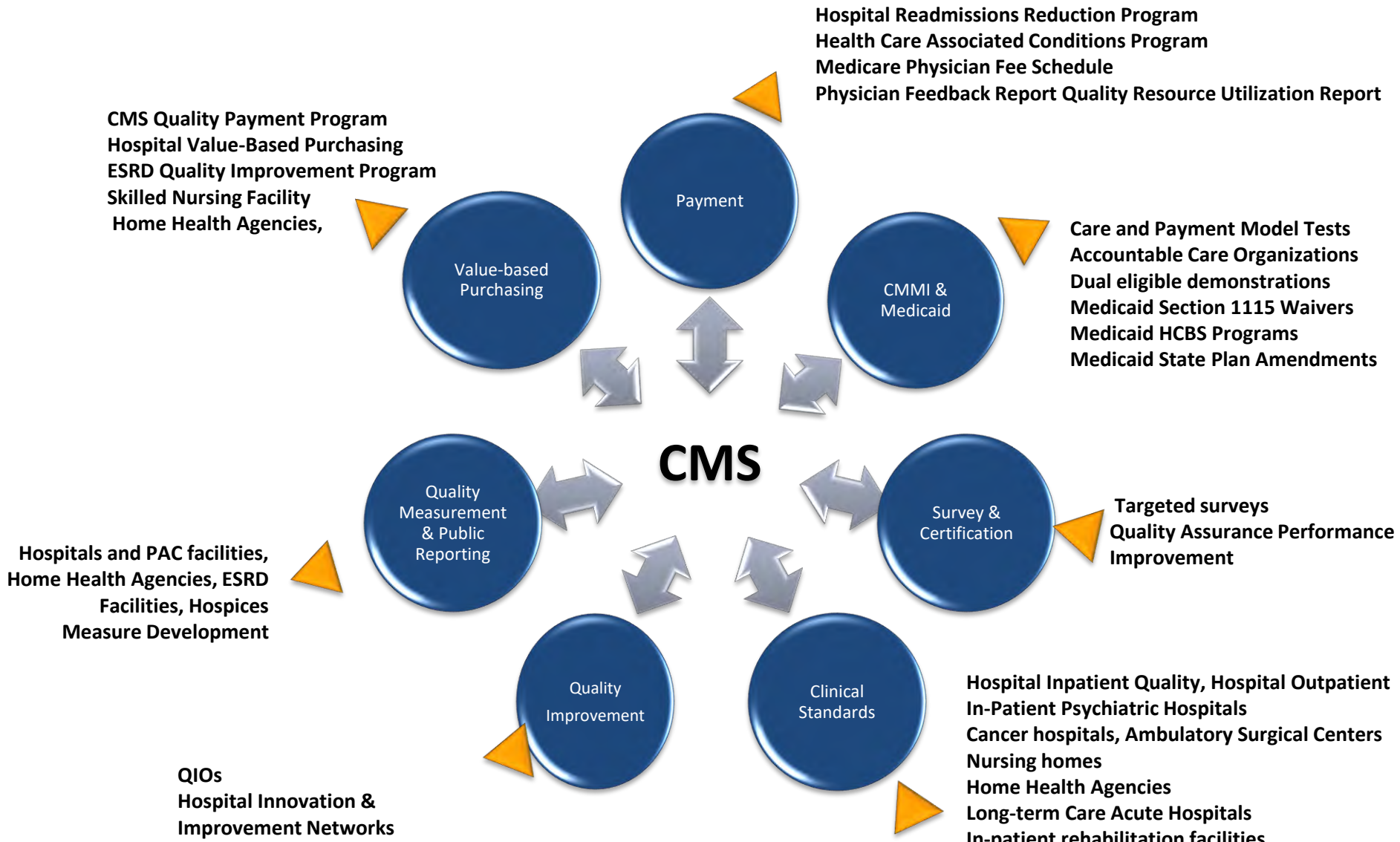
## Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

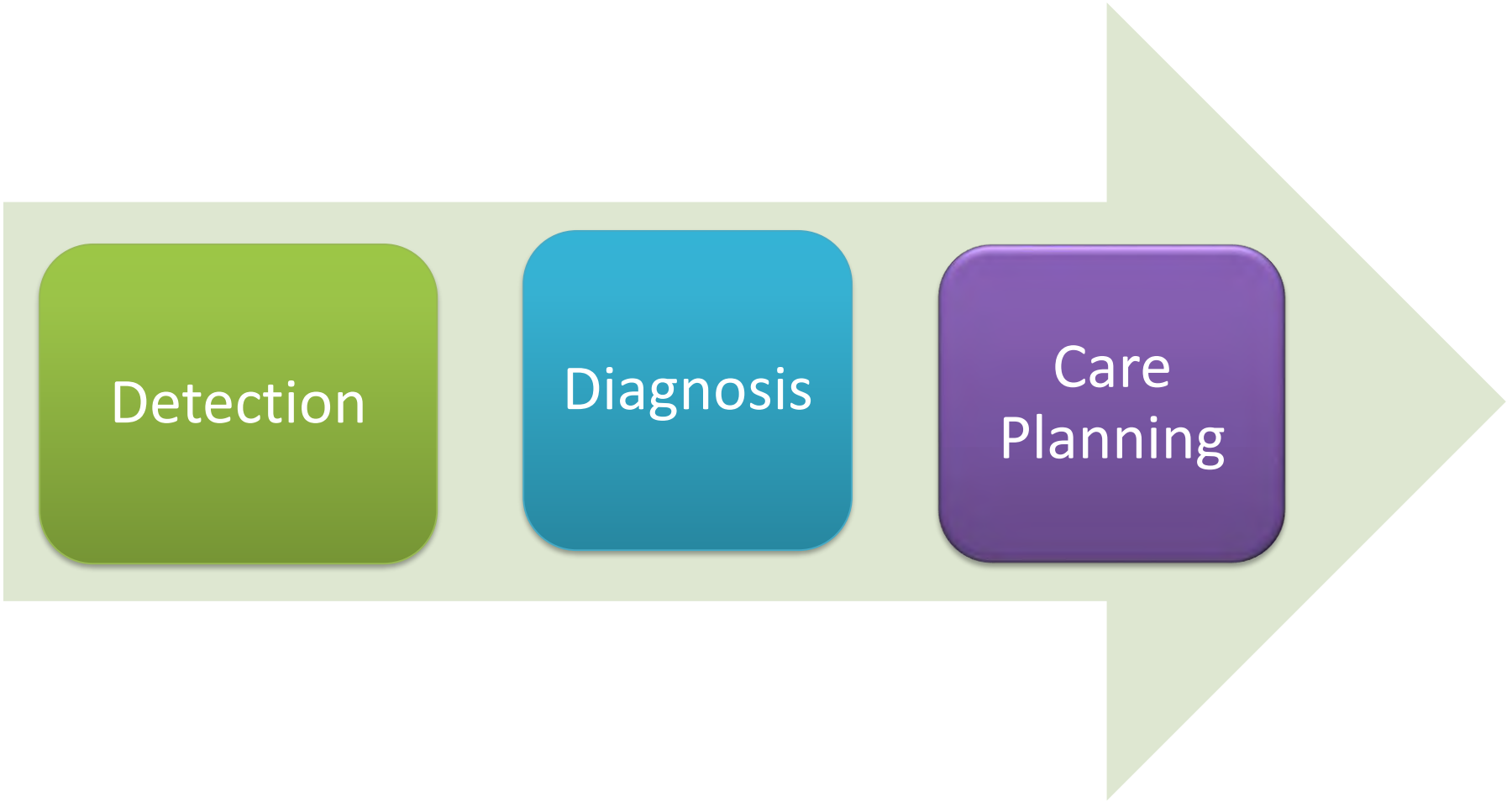
## Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

# CMS Program Authorities



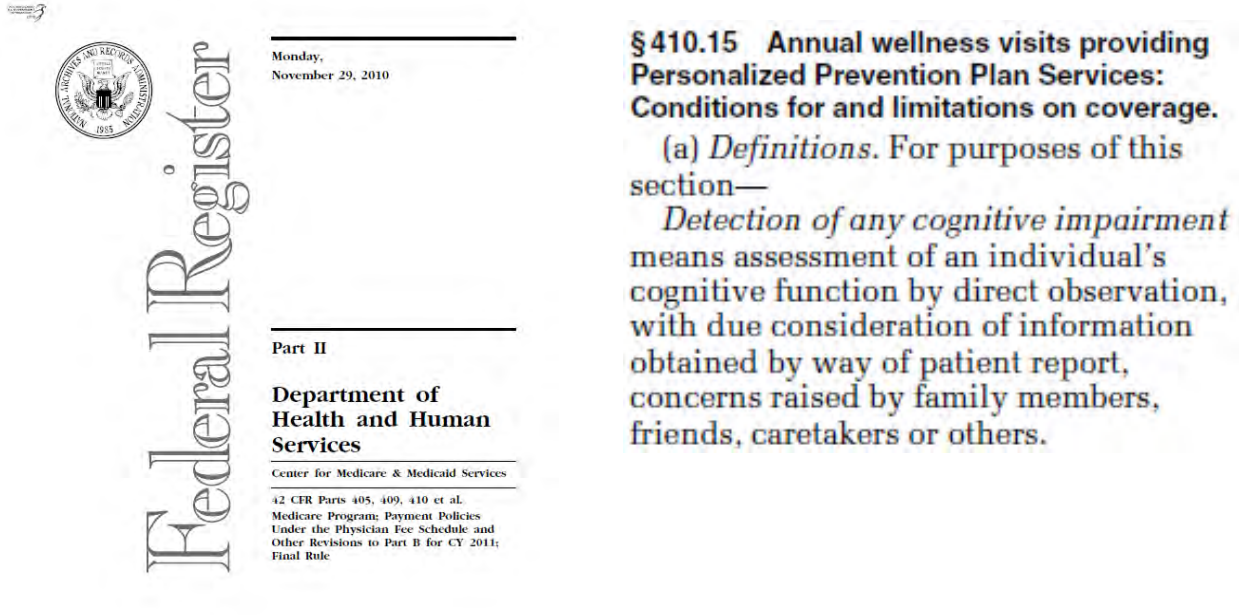
# Clinical Workflow in Caring for Persons with or at risk of Dementia



# Detection of Any Cognitive Impairment

## Statutorily required element of the AWV, added via rulemaking

Federal Register / Vol. 75, No. 228 / Monday, November 29, 2010 / Rules and Regulations



Federal Register

Monday,
November 29, 2010

Part II

Department of Health and Human Services

Center for Medicare & Medicaid Services

42 CFR Parts 405, 409, 410 et al.
Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule

**§ 410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage.**

(a) *Definitions.* For purposes of this section—

*Detection of any cognitive impairment* means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers or others.

- Summary of CMS response to comments:
  - No nationally recognized screening tool for detection of cognitive impairments at present time.
  - Clinicians can use best clinical judgment in the detection and diagnosis of cognitive impairments.
  - We will continue to actively monitor advancements in screening, collaborate with USPSTF, and
  - **We will consider revising this element if the evidence is sufficient and a standardized screening test becomes available.**

# The Preferred Road to Coverage

Provide adequate evidence that…

## Diagnostics

- ✓ The incremental information obtained by new diagnostic technology compared to alternatives
- ✓ Changes physician/clinician recommendations
- ✓ Resulting in changes in therapy
- ✓ That improve clinically meaningful health outcomes

## Therapeutics

- ✓ A treatment strategy using the new therapeutic technology compared to alternatives
- ✓ Leads to improved clinically meaningful health outcomes

**In Medicare beneficiaries**

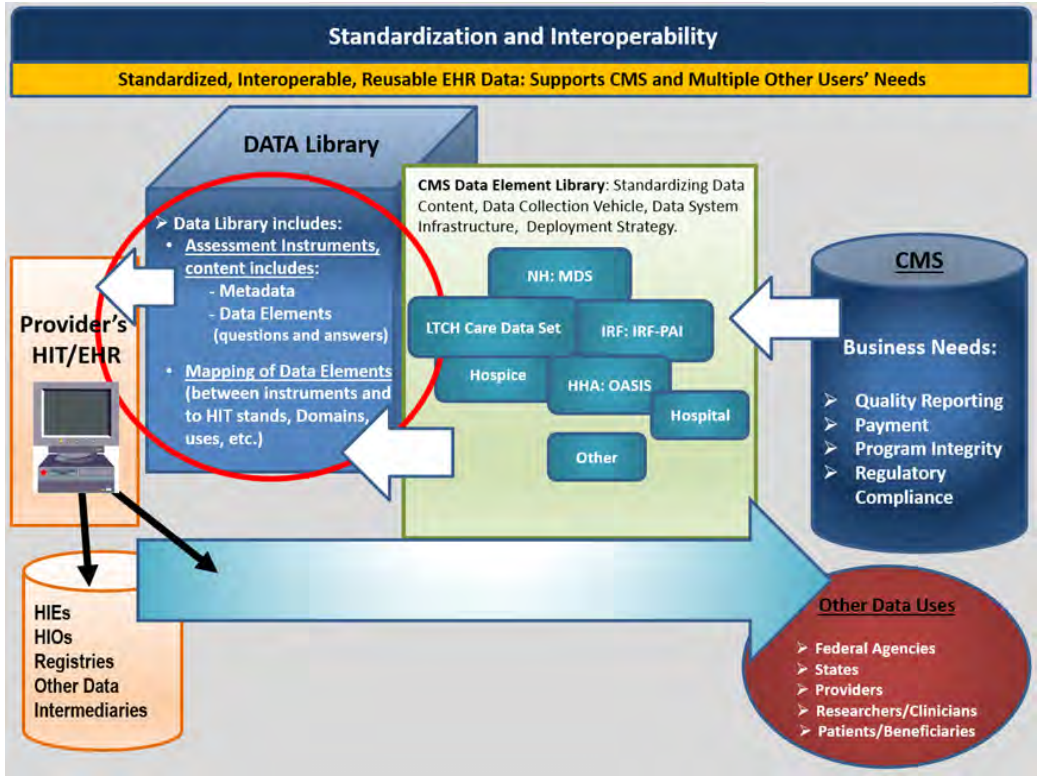
| Procedure | CMS Code |
|---|---|
| Annual wellness visit, first visit<br>Annual wellness visit, subsequent visit[a]<br>Welcome to Medicare exam[a] | HCPCS G0438 and G0439<br><br>HCPCS G042 |
| Chronic care management[a] | CPT code 99490 – cannot be billed during same month as:<br>Transitional Care Management – CPT 99495 and 99496<br>Home Healthcare Supervision – HCPCS G0181<br>Hospice Care Supervision – HCPCS G9182<br>Certain ESRD services – CPT 90951-90970 |
| Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment b | HCPCS G0505 – cannot be billed with 90785 (Psych treatment complex interactive), 90791 (Psych diagnostic evaluation), 90792 (Psych diagnostic evaluation with medical services), 96103 (Psych testing administered by computer), 96120 (Neuropsych test administered w/computer), 96127 (Brief emotional/behavioral assessment), 99201- 99215 (Office/outpatient visits new patient), 99324-99337 (Domiciliary/rest home visits new patient), 99341-99350 (Home visits new patient), 99366-99368 (Team conference with patient by health care professional), 99497 (Advanced care plan 30 minutes), 99498 (Advanced care plan additional 30 minutes) |
| Care transitions[b] | CPT Code 99495 – communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of at least **moderate** complexity and a face-to-face visit within **14** days of discharge<br>CPT Code 99496 – communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of **high** complexity and a face-to-face visit within **seven** days of discharge |
| Advanced care planning[b] | CPT code 99497 for the first 30 minutes, and 99498 for each additional 30 minutes |

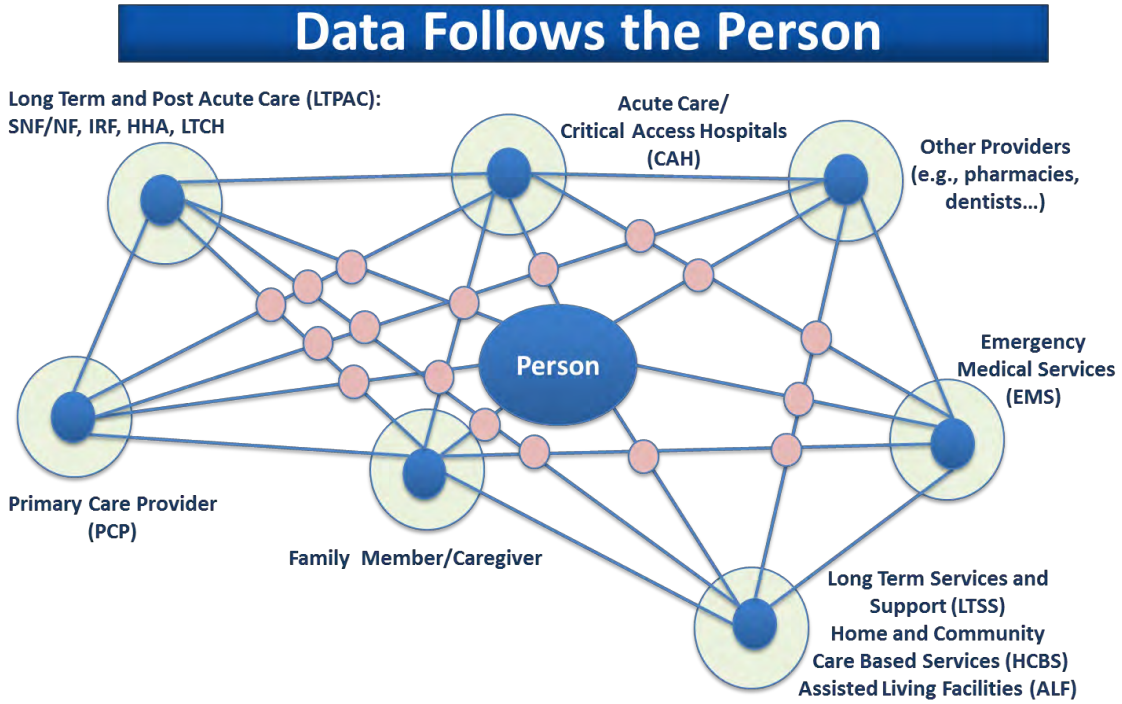
# Dementia eCQMs

- Measures developed based on CMS request to examine evidence base and measurement gaps to develop de novo eCQMs related to dementia care
- Worked with CMS leadership, experts from the Veteran's Administration and the Alzheimer's Association to develop two measures intended to address quality of care for patients at risk of or who have cognitive impairment
  1. Cognitive Impairment Assessment Among Older Adults (75 years and older) – *CI Assessment*
  2. Documentation of a Health Care Partner for Patients with Dementia or Mild Cognitive Impairment – *Health Care Partner*

# The CMS Data Element Library

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014




QUESTION: What are the critical data elements for cognition?

# Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

Bill passed on September 18, 2014, and signed into law October 6, 2014

**The Act requires the submission of standardized patient assessment data elements by:**

- Long-Term Care Hospitals (LTCHs): LCDS
- Skilled Nursing Facilities (SNFs): MDS
- Home Health Agencies (HHAs): OASIS
- Inpatient Rehabilitation Facilities (IRFs): IRF-PAI

**The Act specifies that data** "… be **standardized and interoperable** so as to allow for the **exchange of such data among such post-acute care providers and other providers** and the use by such providers of such data that has been so exchanged, including by **using common standards and definitions** in order to provide access to **longitudinal information** for such providers to **facilitate coordinated care** and **improved Medicare beneficiary outcomes**…".

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

# Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

- The model will support over **140,000 clinician practices** over the next four years to **improve on quality and enter alternative payment models**

- Two network systems will be created

1) **29 Practice Transformation Networks**: peer-based learning networks designed to coach, mentor, and assist

2) **10 Support and Alignment Networks**: provides a system for workforce development utilizing professional associations and public-private partnerships

# Clinical Practice Leaders Have Already Charted the Pathway to Practice Transformation

| Traditional Approach | Transformed Practice |
|---|---|
| Patient's chief complaints or reasons for visit determines care. | We systematically assess all our patients' health needs to plan care. |
| Care is determined by today's problem and time available today. | Care is determined by a proactive plan to meet patient needs. |
| Care varies by scheduled time and memory/skill of the doctor. | Care is standardized according to evidence-based guidelines. |
| Patients are responsible for coordinating their own care. | A prepared team of professionals coordinates a patient's care. |
| Clinicians know they deliver high- quality care because they are well trained. | Clinicians know they deliver high- quality care because they measure it and make rapid changes to improve. |
| It is up to the patient to tell us what happened to them. | You can track tests, consults, and follow-up after the emergency department and hospital. |

TCPI PTN WI: Mayo Clinic: Contact - Dr. Nilay Shah 507-266-5130, Diane Olson 507-293-5759, shah.nilay@mayo.edu; olson.diane9@mayo.edu

**Adapted from Duffy, D. (2014). School of Community Medicine, Tulsa, OK.**

# Question: Which of the Areas are most critical to you, and why?

## Promote Effective Communication & Coordination of Care

Meaningful Measure Areas:

- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

## Promote Effective Prevention & Treatment of Chronic Disease

Meaningful Measure Areas:

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

## Work with Communities to Promote Best Practices of Healthy Living

Meaningful Measure Areas:

- Equity of Care
- Community Engagement

## Make Care Affordable

Meaningful Measure Areas:

- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

## Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measure Areas:

- Healthcare-associated Infections
- Preventable Healthcare Harm

## Strengthen Person & Family Engagement as Partners in their Care

Meaningful Measure Areas:

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Functional Status

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# Meaningful Measures

**Promote Effective Communication & Coordination of Care**
Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Seamless Transfer of Health Information

**Promote Effective Prevention & Treatment of Chronic Disease**
Meaningful Measure Areas:
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
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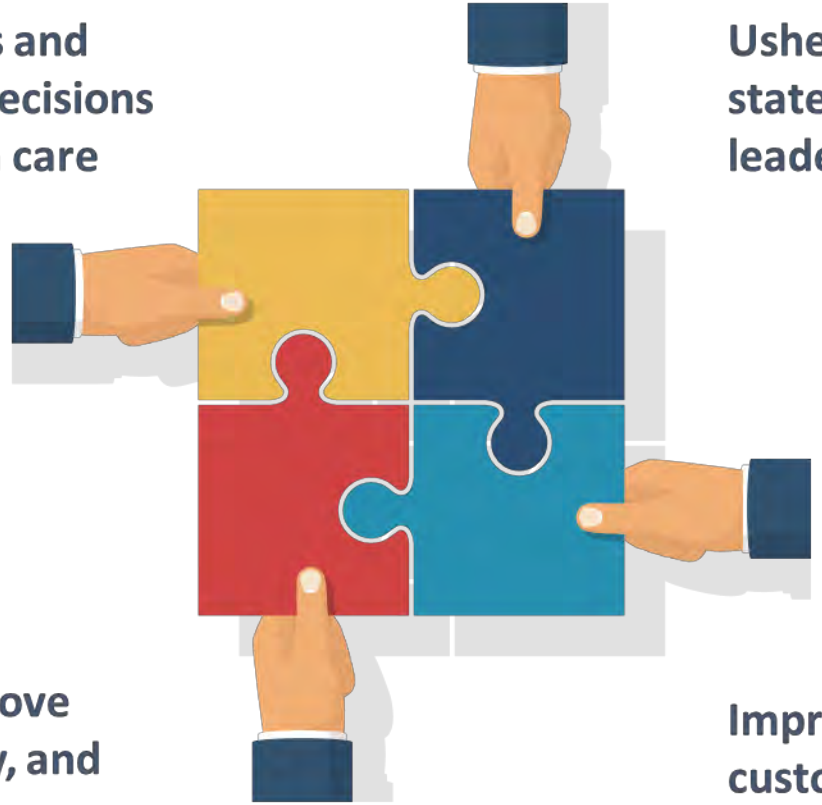
**https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html**

# A New Approach to Meaningful Outcomes

Empower patients and doctors to make decisions about their health care



Usher in a new era of state flexibility and local leadership

Support innovative approaches to improve quality, accessibility, and affordability

Improve the CMS customer experience

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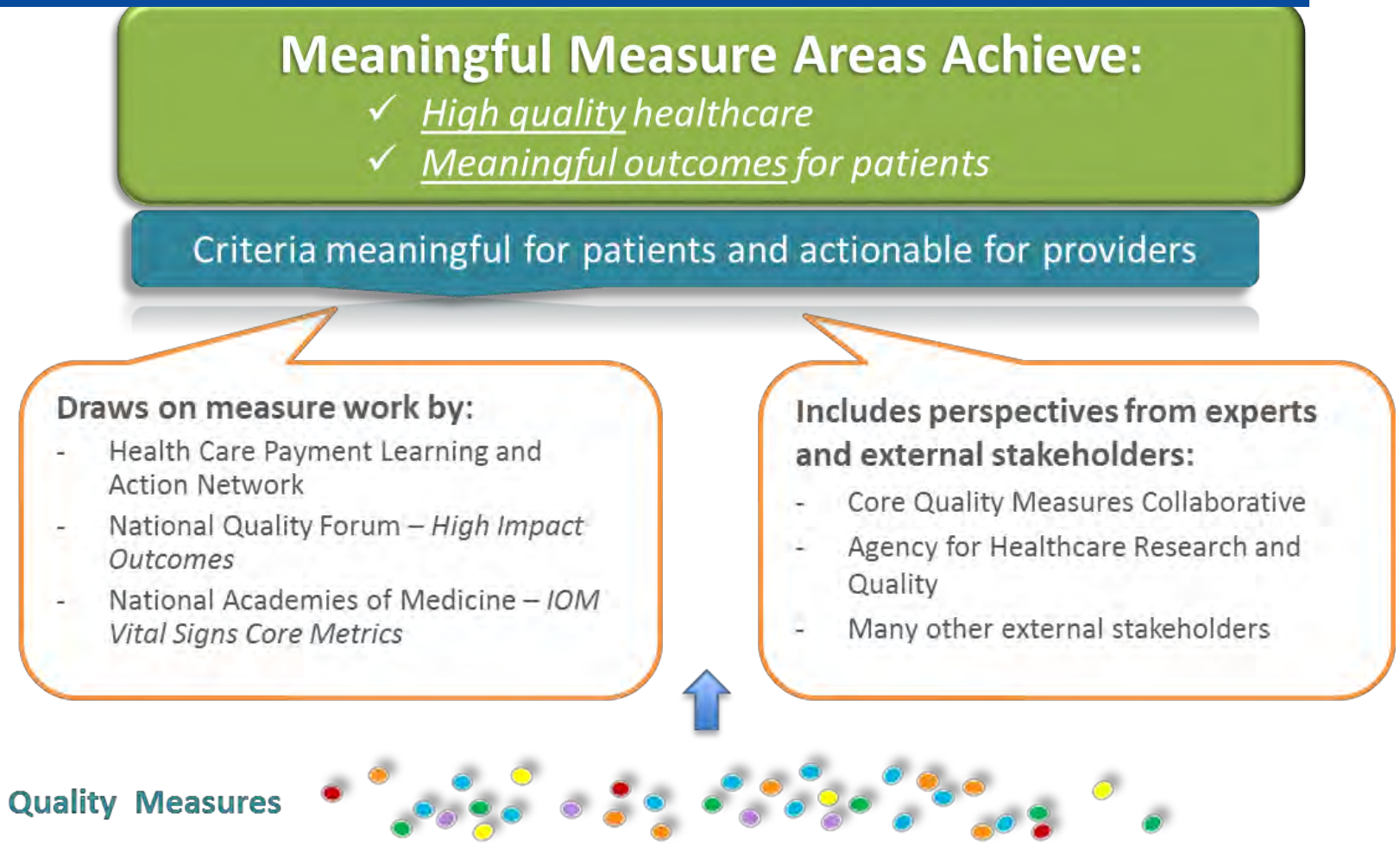
# Meaningful Measures Objectives

**Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity, which can help identify measures that:**

- Address high-impact measure areas that safeguard public health
- Are patient-centered and meaningful to patients, clinicians and providers
- Are outcome-based where possible
- Fulfill requirements in programs' statutes
- Minimize level of burden for providers
- Identify significant opportunity for improvement
- Address measure needs for population based payment through alternative payment models
- Align across programs and/or with other payers

# Meaningful Measures Framework



# Meaningful Measures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**Strengthen Person & Family Engagement as Partners in their Care**

Meaningful Measure Areas:

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Reported Functional Outcomes

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# Strengthen Person & Family Engagement as Partners in their Care (1 of 2)


Person- and Family-Centered Care

Care is Personalized and Aligned with Patient's Goals

End of Life Care according to Preferences

Patient's Experience of Care

Patient Reported Functional Outcomes

Meaningful Measure Areas

## Descriptions

"An alternative approach to better care focuses on [patient goals]...researchers have been using goal-attainment scaling for decades to measure the effect of treatment for conditions such as dementia and for comprehensive geriatric assessments.[3]" Ensure the care delivered is in concert with individuals' goals, aligned with the care plan co-created with their doctor and evidenced by people making informed decisions about their care.

Fewer than 50% of even severely or terminally ill patients have an advance directive in their medical record.[4] Ensure that care delivered at the end of life is in concert with patient/family preferences, which includes knowing those desires and providing aligned care and services.

Recent average positive reports of healthcare experiences showed variation across a range of factors, for example, from 52% for 'Care transitions' to 87% for 'Discharge information.[5]' Actively engage patients in reporting their experiences including satisfaction with care and staff, and community inclusion.

With total knee replacement among the top five most frequent inpatient procedures, more than 50% of inpatients are being discharged home.[6] Improve or maintain patients' quality of life by addressing physical functioning that affects their ability to undertake daily activities most important to them.

# Strengthen Person & Family Engagement as Partners in their Care (2 of 2)


Person- and Family-Centered Care

Care is Personalized and Aligned with Patient's Goals

End of Life Care according to Preferences

Patient's Experience of Care

Patient Reported Functional Outcomes

Meaningful Measure Areas

Measures

- Care plan
  QPP
- Hospice Visits while Death is Imminent
  HQRP
- CAHPS® Hospice Survey: Getting Emotional and Religious Support
  HQRP
- CAHPS In-Center Hemodialysis Survey
  ESRD QIP
- Home and Community Based Services CAHPS
  Medicaid & CHIP
- Functional Status Assessment for Total Hip Replacement
  QPP

**Programs Using Illustrative Measures**

Quality Payment Program (QPP)
Hospice Quality Reporting Program (HQRP)
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Home Health Quality Reporting Program (HH QRP)

# Promote Effective Communication & Coordination of Care (1 of 2)


Effective Communication and Care Coordination

Medication Management

Admissions and Readmissions to Hospitals

Transfer of Health Information and Interoperability

Meaningful Measure Areas

## Descriptions

Annual health care costs in the U.S. from Adverse Drug Events (ADEs) are estimated at $3.5 billion, resulting in 7,000 deaths annually.[7] Avoid medication errors, drug interactions, and negative side effects by reconciling and tailoring prescriptions to meet the patient's care needs.

Nearly 1 in 5 Medicare fee-for-service hospital discharges have previously resulted in a readmission within 30 days.[8] accounting for more than $17 billion in avoidable Medicare expenditures.[9] Prevent unplanned admissions and readmissions to the hospital; unplanned admissions and readmissions have negative impacts on patients, caregivers, and clinical resources, and can be prevented with effective care coordination and communication.

Fewer than 10% of physicians have fully functional electronic medical record/electronic health record (EMR/EHR) systems.[10] Promote interoperability to ensure current and useful information follows the patient and is available across every setting and at each healthcare interaction.

# Promote Effective Communication & Coordination of Care (2 of 2)


Effective Communication and Care Coordination

Medication Management

Admissions and Readmissions to Hospitals

Transfer of Health Information and Interoperability

Meaningful Measure Areas

Measures

- Use of High Risk Medications in the Elderly
  QPP
- Medication Reconciliation Post-Discharge
  MSSP
- Annual Monitoring for Patients on Persistent Medications (MPM)
  QRS
- Drug Regimen Review Conducted with Follow-Up for Identified Issues
  IRF QRP, LTCH QRP, SNF QRP, HH QRP
- Standardized Readmission Ratio (SRR)
  ESRD QIP
- Plan All-Cause Readmissions
  Medicaid & CHIP
- Use of an Electronic Health Record
  IPFQR, QIO

**Programs Using Illustrative Measures**

Quality Payment Program (QPP)
Medicare Shared Savings Program (MSSP)
Health Insurance Marketplace Quality Rating System (QRS)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Home Health Quality Reporting Program (HH QRP)
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Quality Improvement Organization (QIO)

# Promote Effective Prevention & Treatment of Chronic Disease (1 of 2)


Prevention and Treatment of Chronic Disease

Preventive Care

Management of Chronic Conditions

Prevention, Treatment, and Management of Mental Health

Prevention and Treatment of Opioid and Substance Use Disorders

Risk Adjusted Mortality

Meaningful Measure Areas

## Descriptions

Many screening rates, like those for breast (72%), cervical (83%), and colorectal (59%) cancers are below desired levels and reflect disparities across ethnicity/race.[11] Prevent diseases by providing immunizations and evidence-based screenings, and meriting healthy life style behaviors and addressing maternal and child health.

People with multiple chronic conditions account for 93% of total Medicare spending.[12] Promote effective management of chronic conditions, particularly for those with multiple chronic conditions.

Annually, 1 in 5 or 43.8 million adults in the U.S. experience mental illness.[13] Diagnosis, prevention and treatment of depression and effective management of mental disorders (e.g., schizophrenia, bipolar disorder), and dementia (e.g., Alzheimer's disease) with emphasis on effective integration with primary care.

Annually, 3 out of 5 drug overdose deaths involve an opiod,[14] resulting in over $72 billion in medical costs.[15] Ensure screening for and treatment of substance use disorders, including those co-occurring with mental health disorders.

Heart disease, cancer, and chronic lower respiratory diseases are among the leading causes for death.[16] Reduce mortality rate for patients in all healthcare settings.

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# Promote Effective Prevention & Treatment of Chronic Disease (2 of 2)


Prevention and Treatment of Chronic Disease

Preventive Care

Management of Chronic Conditions

Prevention, Treatment, and Management of Mental Health

Prevention and Treatment of Opioid and Substance Use Disorders

Risk Adjusted Mortality

Meaningful Measure Areas

**Programs Using Illustrative Measures**

Quality Payment Program (QPP)
Home Health Quality Reporting Program (HH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Hospital Value-Based Purchasing (HVBP) Program

**Measures**

- Influenza Immunization Received for Current Flu Season — HH QRP
- Timeliness of Prenatal Care (PPC) — Medicaid & CHIP
- Well-Child Visits in the First 15 Months of Life (6 or More Visits) — Medicaid & CHIP
- Osteoporosis Management in Women Who Had a Fracture — QPP
- Hemoglobin A1c Test for Pediatric Patients (eCQM) — Medicaid & CHIP
- Follow-up after Hospitalization for Mental Illness — IPFQR
- Alcohol Use Screening — IPFQR
- Use of Opioids at High Dosage — Medicaid & CHIP
- Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization — HVBP

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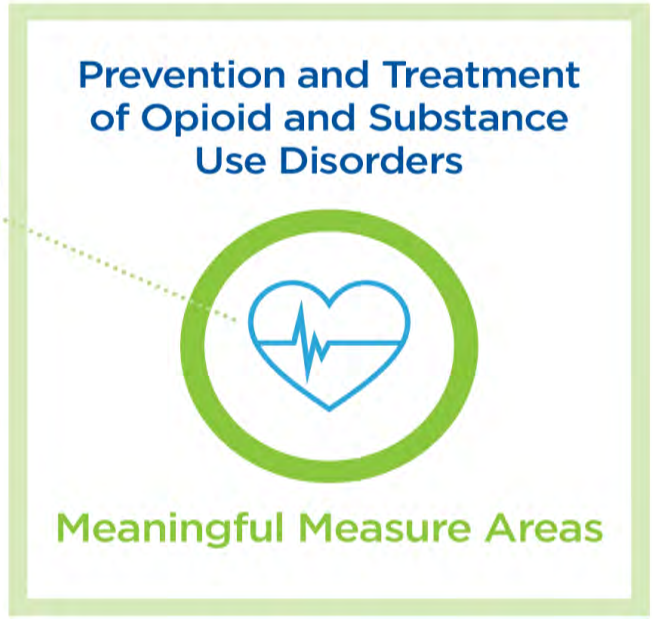
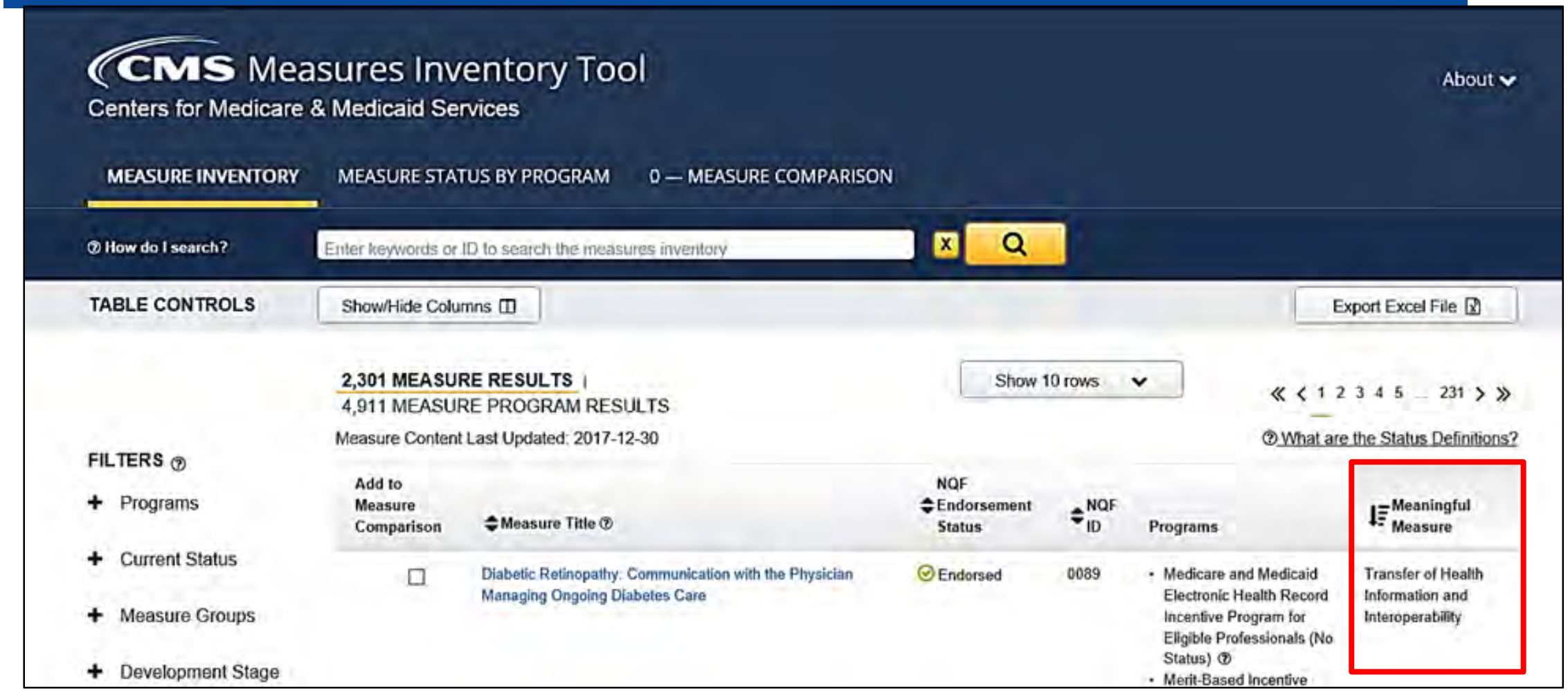
# Promote Effective Prevention & Treatment of Chronic Disease – Example


## Measures

- **Alcohol Use Screening**
  Inpatient Psychiatric Facility Quality Reporting Program
- **Use of Opioids at High Dosage**
  Medicaid & CHIP

# Where to Find Meaningful Measures




CMS Measures Inventory Tool: https://www.cms.cmit.gov

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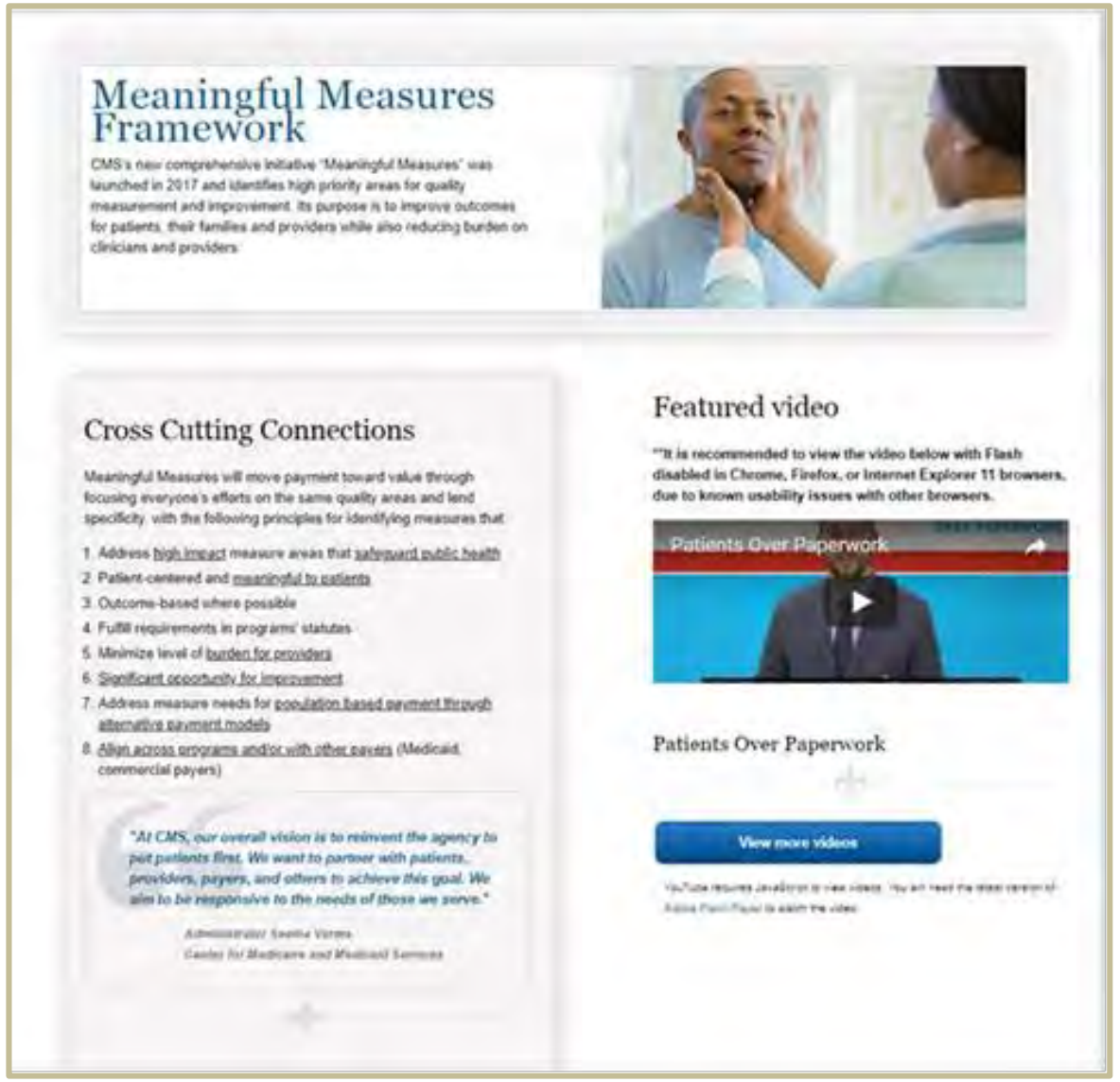
# Meaningful Measures Website

**Go to:**

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html

Give us your feedback!

MeaningfulMeasuresQA@cms.hhs.gov



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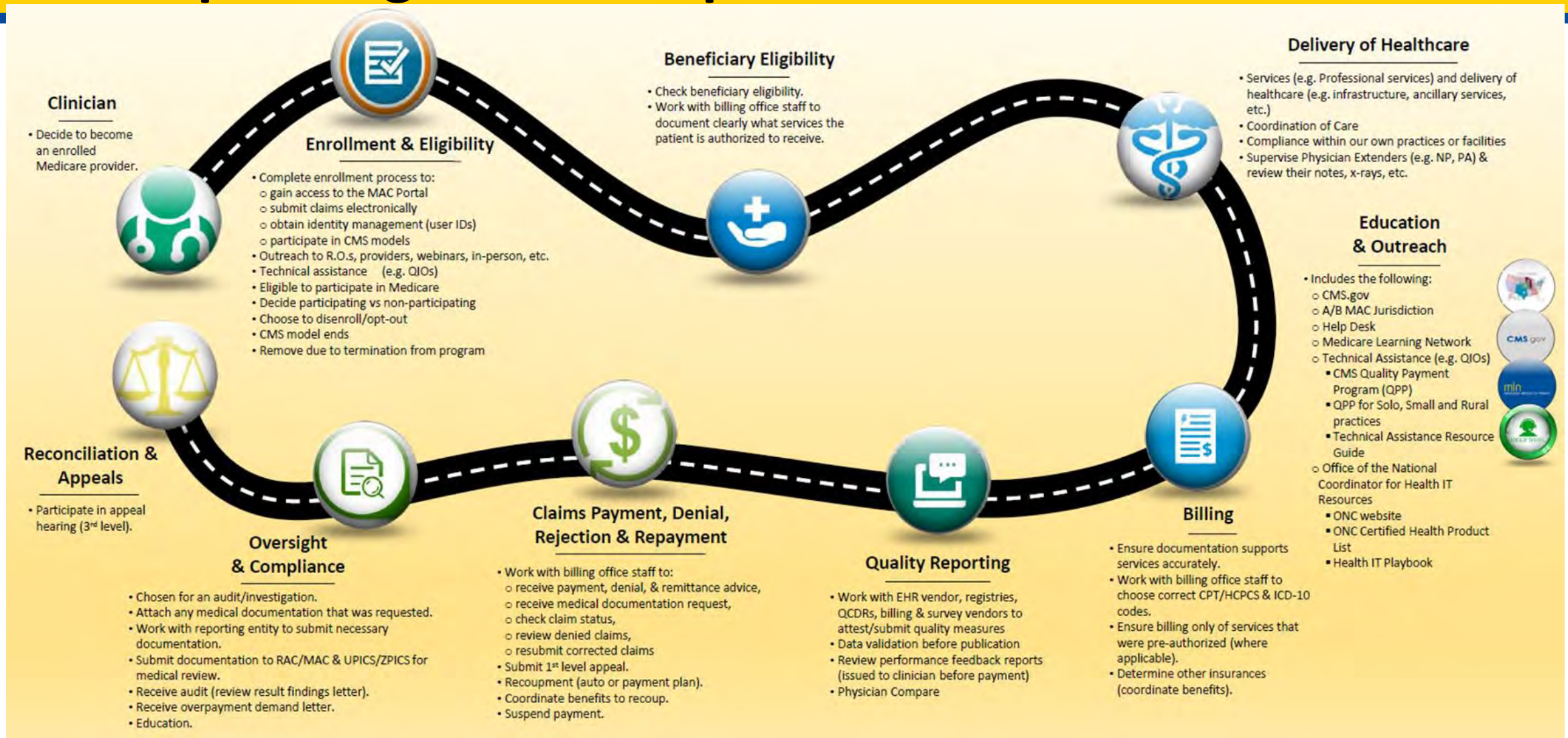
# Patients Over Paperwork - CMS is moving the needle and removing regulatory obstacles that get in the way of providers spending time with patients and consumers



# Thank you!

Contact

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